



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

American Specialty Pharmacy

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-15-2386-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

April 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$143.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute resolution received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2015	Tramadol, Meloxicam 15mg	\$143.20	\$143.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims not subject to certified networks. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims not subject to a certified network.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 790 – This charge was reimbursed in accordance to the Texas medical fee guidelines
 - D20– Previously denied by adjuster with PBM
 - P12 – Workers' compensation jurisdictional fee schedule adjustment

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 10, 2015. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involved the commercially available, FDA-approved drugs, Tramadol HCL and Meloxicam. The insurance carrier denied disputed services with claim adjustment reason code D20 – "Previously denied by adjuster with PBM" and P12 – "Workers' compensation jurisdictional fee schedule adjustment." Review of the submitted documentation finds insufficient information to support the carrier's denial. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.503 (c) states,
The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

(C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

The services in dispute will be calculated as follows:

Dates of Service	Prescription Drug	§134.503 (c) (1)(B)	Maximum Allowable Reimbursement
January 8, 2015	Tramadol 65162062711	$0.82390 \times 60 = \$49.974$ $\$49.974 \times 1.25 = \62.47 $\$62.47 + 4 = \66.47	\$66.47
January 8, 2015	Meloxicam 68382005105	$4.844.94 \times 30 = \$145.347$ $\$145.347 \times 1.25 = \181.68 $\$181.68 + 4.00 = \185.68	\$185.68
	TOTAL		\$252.15

3. The total amount allowed for the services in dispute is \$252.15. The requestor is seeking \$143.20. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$143.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$143.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	August 31, 2015 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.